RELEASE OF INFORMATION AUTHORIZATION

Resident's Name (Printed):_____Date of Birth: _____
Address: _____
Social Security#: _____ Telephone:_____

Authority to Release Protected Health Information

I hereby authorize _____ to release the information identified in this authorization form from the medical records of _____ and provide such information to:

_____

Information to be Released -- Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released

____ Complete health record	__x_ Diagnosis & treatment codes	____ Discharge summary
____ Progress notes	__x_ History and physical exam	_x__ Consultation reports
____ Itemized Bill	____ X-Ray films/images	_x__ Laboratory test results
____ Photographs, videotapes	__x_ X-Ray reports	_x__ Immunization Records

_x__ Other, (specify) _1) Current completed 224 and 2) PPD results w/in 1 year_____.
3) all that are applicable: Power of Attorney, Living Will, copy of insurance cards, and PPD result_____

Purpose of the Requested Disclosure of Protected Health Information

I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be at the request of the individual):
At the request of the individual for transfer to new facility_____

Drug and/or Alcohol Abuse and/or Psychiatric and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to release. Check One: _x__Yes ____ No

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. Check One: _x__Yes ____No

(over)

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to the LWVH, Medical Records Department. Unless revoked, this authorization will expire on the following date, or after the following time period or event (date): _transfer of documents to new facility is complete_____

Re-disclosure

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Acknowledgement of Authorization

I understand that I do not have to sign this authorization. My treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party, I understand that services may be denied if I do not authorize the release of information related to such health care services to the third party. I can inspect or copy the Protected Health Information to be used or disclosed. I hereby release and discharge the LWVH of any liability and the undersigned will hold LWVH harmless for complying with the LWVH authorization.

_____	_____	_____
Resident/Authorized Representative's Signature	Date	Relationship
_____	_____	
Witness	Date	